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ABSTRACT

These guidelines for relationships of academia, professions, and agencies in mental health were developed for persons responsible for conducting professional continuing education programs in mental health. Following a brief introduction and definitions of terms, content is presented in six sections covering the following areas, respectively: (1) the relative responsibilities of professional schools, professional societies, and mental health agencies in providing professional education in mental health, (2) the strengths and weaknesses of academia in continuing education regarding clinical education, teaching methodologies, awarding of credits, assessing needs, scheduling of programs, evaluation, sponsorship and joint use of faculty, and funding, (3) continuing education in professional societies and professional society mandates for continuing education, including their strengths and weaknesses in assessing needs, planning programs, instruction, and funding, (4) continuing education in mental health agencies, focusing on their advantages and disadvantages in assessing needs, planning programs, agency sanctions, instruction, and funding, (5) issues in continuing education in mental health, such as planning and arranging programs, didactic versus experiential instructional methods, credentialing, evaluation, single disciplinary versus interdisciplinary programs, academic rigor versus pragmatism, assessing demand versus need, voluntary versus mandatory continuing education, and funding by fees versus funding by regularly budgeted funds, and (6) the coordination of continuing education in mental health. Finally, a summary concludes these guidelines. (EM)

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RELATIONSHIPS OF ACADEMIA, PROFESSIONS AND AGENCIES

CONTINUING EDUCATION IN MENTAL HEALTH

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FOREWORD

In late 1975 the Mental Health Program of the Southern Regional Education Board (SREB) received a grant (No. 1-T15-MH14098) from the Continuing Education Branch of the National Institute of Mental Health to strengthen continuing education for mental health throughout the 14 states of the South. The project conducted a survey of continuing education activities then underway in the professional schools, professional societies and mental health agencies (both state and community) of the South to learn more of the needs and problems which were being encountered. Responses indicated that there were several areas of general concern: funding, needs assessment, evaluation, gaining sanction for continuing education, credentialing, greater clarification of continuing education responsibilities between the professional schools, the professional societies and mental health agencies, continuing education for professionals, continuing education for community caregivers, etc.

A major strategy of the project has been to appoint task forces of small groups of knowledgeable persons to explore some of these issues in detail and to prepare guideline publications which might be of use to persons presently responsible for conducting continuing education programs in mental health or for those persons who may be coming into positions where they will be developing such programs in the future.

We are grateful to the members of the task force who helped develop these guidelines for relationships of academia, professions and agencies in mental health continuing education and to the National Institute of Mental Health for support of this entire project.

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Health in the South

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INTRODUCTION

Until recently there has been little systematic attention to continuing education in mental health. The field of mental health has traditionally been led by a handful of major professions (psychiatry, clinical psychology, social work and nursing), each trained and certified with no great concern for future change or development. However, the past ten years have seen great changes in treatment technology (e.g., new psychotropic medications, behavior modification, reality therapy); in new modes of service delivery (e.g., prevention, consultation, education, deinstitutionalization); and in new administrative forms (e.g., community mental health centers, halfway houses, alcohol and drug abuse centers).

Many new kinds and levels of workers in the mental health system (i.e., mental health technicians, alcohol counselors, drug counselors) also have developed. With all of these changes it has been necessary to establish a range of continuing education programs to help staff at all levels to keep up-to-date with the new technologies and to help them function effectively in the delivery programs and agencies.

Sporadic continuing education programs have been carried out by various parts of the mental health manpower system over the past fifty years. Most of these efforts were conceptualized as sessions concerned with new scientific and clinical discoveries rather than as continuing education programs concerned

with helping practitioners solve their practice problems, but they were the best that was available. There were also periodic lecture series conducted by professional schools for practicing professionals, but these were rare. None of these programs paid much attention to educational issues, and none was accredited or awarded certificates or credits.

Today the situation is much more complicated. In response to changes in the mental health delivery system and pressures from third-party payers and government for quality assurance, a bewildering array of continuing education programs in mental health has developed. These programs tend to be planned with rather narrow goals and they are poorly coordinated with each other. Some are sponsored by professional societies, some by professional schools, some by operating agencies, and some by profit-making groups or voluntary associations. Some are long-term, others are short-term. Some are accredited and award certificates, while others do not. Some remain focused on scientific lectures which are conducted exclusively for members of a single profession. Others use experiential learning techniques and are directed more to improving delivery programs for multi-disciplinary programs. With all of this activity there has been little attention to the means of coordinating and relating continuing education to the broad field of mental health -- a system made up of many professions, agencies and community caregivers using a wide range of technologies and delivery forms.

DEFINITIONS

For the purposes of this report it is desirable to agree upon the definition of certain terms so that we can "box the compass" for further discussions. Among key terms are:

> Continuing Education -- any systematic learning experience to improve, modify or update one's knowledge, skills or values in areas of professional or occupational practice.

Some definitions include the notion of any kind of life-long learning in the concept of continuing education (i.e., learning to play golf, to appreciate art or to raise orchids). The definition for purposes of this publication is limited to professional or occupational practice.

Other authors would limit the meaning to formally accredited programs or even to programs sponsored by colleges or universities. The definition used here is not so restrictive and includes programs sponsored by operating agencies, professional societies or private and voluntary associations. This definition also includes regular self-study programs and individual use of programmed instruction materials, but not casual readings or attendance at professional society business meetings. The learning experience does not need to be accredited or systematically assessed to meet this definition, although it is desirable that any continuing education program be evaluated.

Mental Health -- the field of knowledge and applied techniques which is concerned with mental and emotional health and illness of the population and the social systems which help to enhance the psycho-social functioning of individuals with poor coping patterns.

This includes all of the areas of mental illness, mental retardation, emotional disturbance, alcohol and drug abuse, as well as prevention of these conditions and promotion of the mental health of the population at large. It is not restricted to what mental health agencies and their staffs do, but extends to any activities of other community agents or agencies which affect the mental health of the people. It encompasses at least three major areas of competence:

Clinical knowledge and skills about the causes and diagnoses of various emotional or mental disabilities and the skills to intervene on behalf of individuals or small groups.

This is the area of professional competence that is traditionally offered in pre-professional training and in continuing education. It is a basic and essential aspect of mental health practice, but it is often not sufficient to provide for the efficient delivery of mental health services.

Knowledge and skills for the delivery of mental health services to clients and communities.

These service delivery skills go beyond the basic clinical skills of diagnosis and treatment and include such competencies as prevention, mental health education, consultation, and rehabilitation. Also included are such concepts as the use of teams, community process skills, assuring patient compliance and maintaining support systems for clients who have been released from acute treatment but still require extensive assistance in order to function in the community.

Knowledge and skills for administration of programs, funds, and personnel to deliver mental health services.

> Most mental health professionals (and even paraprofessionals) soon find themselves involved in administrative or supervisory responsibilities for units of programs or for entire programs, often in addition to their clinical and service delivery duties. Very few pre-professional training programs prepare their graduates for any kind of administrative skills. This area is left either to continuing education or to the "school of hard knocks" that comes with experience.

The four major components in the mental health continuing education system are: a) the professional schools, b) the professional societies, c) the operating mental health agencies, and d) private and voluntary groups. They are all relative newcomers to the field of continuing education -- a field which itself is new and not yet well conceptualized.

> Academia -- the formally structured educational system.

This includes all components of the educational system in public and private colleges and universities, community colleges, and technical centers, as well as governing bodies such as boards of higher education. The professional schools of the major mental health professions are usually located in universities or colleges.

> Professional societies -- organizations of professional technical or occupational groups focused on the improvement of their members individually and collectively.

Often the professions are strongly oriented to political advocacy and protection of their prerogatives, but they are also concerned with the betterment of their members through scientific programs, journals, training endeavors and certification and licensure activities. This definition includes

paraprofessional organizations and affiliates, such as the American Public Welfare Association and the American Public Health Association.

> Agencies -- formally structure organizations which deliver mental health services.

The usual provider agencies of mental health services are state mental health agencies, community mental health centers, mental hospitals, schools for the retarded, alcohol and drug programs, children's programs and counseling centers. In addition to these, Health Systems Agencies, Professional Standards Review Organizations, and mental health associations might be considered to be agencies. The term includes public, private and voluntary agencies. Agencies must be concerned about the competence of their staffs to carry out the clinical, programmatic and organizational functions for which they are responsible.

> The private and voluntary sector -- those individuals, companies and proprietary groups which provide continuing education on a profit making or cost basis.

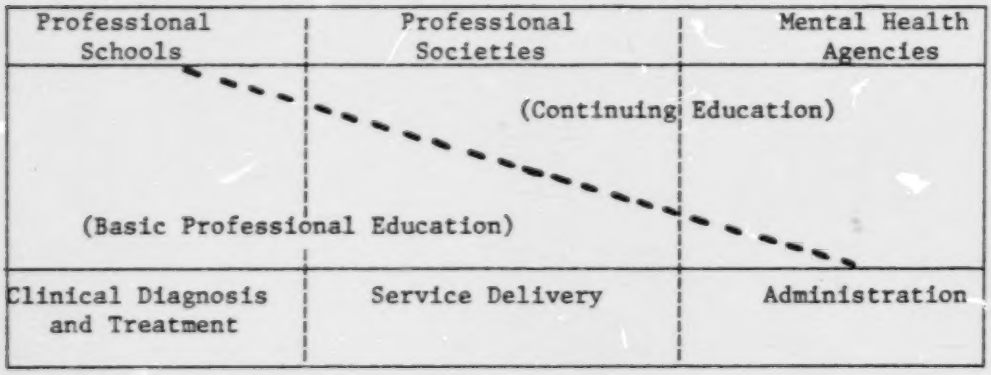
This includes firms and private consultants sponsoring workshops, media preparation, programmed instructional materials and training conferences. These consultants, pharmaceutical corporations, profit-oriented institutes, proprietary educational organizations and associations, such as the American Management Association, may have other purposes, but they also sponsor continuing education programs on a cost or profit making basis.

The private and voluntary sector is not a part of the official system, but it has become active in meeting the new demands. It is important that its role be more sharply defined and recognized by persons in the official system.

RELATIVE RESPONSIBILITIES OF THE FOUR COMPONENTS

There has been a widespread concept that continuing education in mental health is concerned primarily with clinical diagnosis and treatment. Thus there has been an initial impulse to schedule all continuing education activities in terms of clinical knowledge and skills. It has been only recently that the needs for continuing education in service delivery and administration have become evident. These have been areas of increasing concern for professional societies and operating agencies. The emerging pattern of primary concerns of the three official component groups involved in education in mental health might be diagrammed as follows.

MENTAL HEALTH



These are not exclusive areas of concern for each component group, but rather, represent the center of gravity of each. While most persons think of

the traditional area of clinical knowledge and skills when they refer to continuing education, the major problem areas and needs presently lie in the domains of service delivery and administration. These are areas for which virtually all workers must depend on continuing education since they are not taught in basic professional education.

At present most professional schools are moving to establish continuing education programs. The professions are sponsoring more continuing education, and their associations are moving to make continuing education mandatory for continued membership, certification or even licensure. The mental health agencies are expanding their staff development and continuing education programs; and there are more privately sponsored training programs. There is little overall coordination of these pieces.

As the system of continuing education for mental health expands, there will be more and more issues to be addressed and coordinated. As long as continuing education remained a sporadic activity of concern to only a few persons who had other primary responsibilities, there was no need for a planned coordinated system. However, as the need for continuing education has become more apparent, and as the various components of the system have moved to develop programs, there is need for a more carefully considered framework which will make all of the activities most effective at the least cost.

CONTINUING EDUCATION IN ACADEMIA

The academic system has had responsibility for basic professional and occupational education in mental health for the past several decades, since the days when professional training ended the era of apprenticeship or in-service work. Professional and occupational education was moved into the higher educational system to provide a stronger scientific and knowledge base, but it led to a departmentalization of the professions, each with its own school or division and each with its separate body of knowledge, skills and values. The predominant training emphasis in most of the professional schools has been on the diagnosis and treatment of psychopathology in individual persons. This one-to-one role model has been characteristic of virtually all the mental health professions. At the same time, there has been little teaching about the overall delivery of services or about the administration of programs in which the services are delivered.

As the colleges and universities have moved into the area of continuing education, they have carried over these patterns. Thus there has been a tendency to design continuing education to up-date and improve the diagnostic and treatment skills for the members of a single profession, rather than placing emphasis on training for delivery services in a multidisciplinary program.

SPECIAL COMPETENCE IN CLINICAL EDUCATION

The area of clinical competence is a special strength of the colleges and universities, as they have faculty persons who keep abreast of the latest knowledge, treatment techniques and teaching resources, such as books and journals. In many cases the faculty's research work gives added depth in the teaching of pathology and therapy of individual patients.

The particular strength of academicians is the knowledge dimension of clinical practice. Academia has relatively less strength in the areas of skills and values, but even here, the capability of academia is likely to be high. At times academicians may be preoccupied with ideal models of therapy and research knowledge to the detriment of practical applications of the knowledge. While this may be true of the basic science researcher in academia or the professor who uses abstract concepts and highly technical jargon, it is possible to caution those persons to avoid this tendency in teaching continuing education programs.

TEACHING METHODOLOGIES

One of the special strengths of academia in the area of continuing education is expertise in a wide range of teaching methods. There are specialists in all kinds of experiential learning techniques -- gaming, simulations, role playing, videotape playback, etc. The professional schools are also likely to have many kinds of equipment -- film projectors, videotape machines and audiotape machines which enrich continuing educational programs. Libraries are close at hand and can be counted upon to provide reference material for extra readings. All of these resources need to be made available

to the other major component groups as well as to those continuing education programs sponsored by academia.

Occasionally a teacher from academia will maintain his professorial posture when teaching in a continuing education program. This is likely to be resented by the learners who prefer to be treated as colleagues rather than as school children. Instructors are best received who come to continuing education programs as consultants to help colleagues solve their practice problems rather than as professors telling students what to do.

LIMITATIONS OF ACADEMIA

Academic institutions have some difficulty in conducting continuing education programs which focus on the delivery of services and mental health administration. These are both complex subjects which usually require an interdisciplinary approach, but it is often difficult to bring several departments of a college or university together -- especially if departments of Business Administration and Public Administration are involved in addition to several clinical departments. Differences in terminology and values often must be overcome.

Perhaps the greatest limitation of academia lies in the fact that each clinical department of the university tends to focus on a one-to-one model of diagnosis and treatment, each profession using a role model which puts its specialty in the central position in therapy. There is little concern for team models or other approaches to delivering services. Furthermore the various professional schools are often committed to entirely different philosophical approaches to therapy -- the medical model, the behavioral

model, the social model, the educational model, the psychoanalytic model, etc. If these positions are doctrinarily maintained, there will be difficulties in addressing the problems of service delivery in the field.

Another problem faced by academia in attempting to teach about service delivery or administration is that the knowledge base for teaching in these areas is often not firm and tends to be time-and-agency bound. The principles and skills are not as scientifically based as are clinical knowledge and skills. What is needed is more of a problem-solving approach rather than the traditional didactic approach. Many academicians are uncomfortable or even disdainful of this approach and are reluctant to associate themselves with what they feel are primarily pragmatic and political matters. Because of these problems, continuing education programs directed to service delivery and administration are more likely to be sponsored by professional societies or agencies.

There are several administrative issues which are either advantages or disadvantages in having academia conduct continuing education programs for mental health practitioners.

AWARDING OF CREDITS

A distinct advantage of having an academic institution sponsor a continuing education program is that the college or university is very likely to be able to award some kind of credit or certificate. Higher education institutions are in the business of awarding credits and degrees. It is a rather simple matter for them to agree to award Continuing Education Units (CEUs) or other kinds of recognition such as Category I Continuing Medical

Education credits for the Physicians' Recognition Award of the American Medical Association. In a few cases the colleges or universities may allow a person to aggregate CEUs toward credits for a regular academic degree. This may be an important issue for those practitioners at middle levels who hope to advance to higher degrees and to higher level positions. In many situations it might be desirable for a four-year academic institution or a community college to co-sponsor a continuing education program with a local agency or professional society in order to more easily grant such credits.

ASSESSING NEEDS

There are certain limitations of academia when it comes to assessing needs. While academic institutions have excellent needs assessment technologies, they often do not have ready access to local practitioners or agency staff persons in order to fully assess the needs for continuing education. There is a tendency for professional schools and programs to do relatively little follow-up of their own graduates in order to plan continuing education programs. The typical pattern is for the faculty to decide among themselves what subject, format, etc. shall be used for a continuing education program. Academic institutions should make special attempts to work with professional societies and agencies in the determination of practitioners' needs for continuing education programs.

SCHEDULING OF CONTINUING EDUCATION

Difficulties may be presented when a university system schedules a continuing education program. Academic institutions are sometimes locked-in to a fixed time and place for conducting continuing education programs. These

arrangements are frequently not convenient for the practitioners who are expected to attend them because the programs are scheduled only during regular academic hours or during interterm recesses, or because the programs are all scheduled on campus. Academia would do well to pay close attention to the practice patterns of the practitioners and schedule the continuing education programs at times and places which are most convenient.

EVALUATION

Within academia there are evaluation and research skills and tools which are superior to those in the other components of the continuing education system. These should be used not only for evaluation of the programs sponsored by academia, but through consultative or contractual arrangements, also for those of the other components.

RESTRICTIONS ON SPONSORSHIP AND JOINT USE OF FACULTY

While joint sponsorship of continuing education programs with agencies and joint use of agency persons as faculty is often desirable, the policies of a university system sometimes makes this difficult. Academic institutions must be sure that they are establishing liaison arrangements with reputable groups and that faculty from agencies are competent. Jointly sponsored programs, if they can be arranged, frequently will enhance continuing education programs and agencies and professional societies will be inclined to lend financial support and sanction.

FUNDING FOR CONTINUING EDUCATION

The matter of funding presents a serious problem for all component groups in continuing education in mental health. Most academic institutions have not

yet made a substantial hard money commitment to continuing education. Continuing education programs are expected to "pay their own way" or even to make a profit. This means that the director of continuing education in a professional school must be a promoter who plans and advertises programs that will "sell." This can lead to programs on exotic subjects which will draw a large attendance. Sometimes the size of the group works against really effective learning, but this is necessary so that the overall continuing education program will pay its way.

Fees paid by participants can be expected to cover the instructional costs for individual offerings, but little more. The financial support for the overall administration of continuing education programs must come from elsewhere -- grants, contracts or regular institutional funds. It is expected that hard money will become much more common as colleges recognize that continuing education is both a major community service and a substantial component of higher education along with liberal arts, occupational and basic professional education.

Increasingly colleges and universities are establishing full-time or part-time continuing education offices from regular college funds rather than from soft money alone. This appears to be essential if the college is to have an effective continuing education program based on need rather than on salesmanship. Such an office is needed to assess needs, plan and evaluate programs, arrange meeting places and instructors, award certificates, keep records and assume responsibility.

CONTINUING EDUCATION IN PROFESSIONAL SOCIETIES

The professional societies were the first of the three official component groups to have continuing education programs as part of their effort to enhance the competence of the profession and to help members keep up-to-date with new developments. These efforts were traditionally carried out through the scientific sessions and the scientific journals of the profession. Programs soon developed into the typical "scientific" format with presentations of research developments of a technical sort followed by a formal discussion by a single reactor or by a panel of reactors. Many national professional societies presently have program committees and editorial boards which referee the papers being considered to assure that they are of the highest research quality. While this procedure produces presentations and publications of high scientific quality, the topics are often not on subjects or in formats which would be most helpful in solving the problems of members' everyday practices. They have thus lost the continuing education advantages for which they originally came into existence. This is particularly true of many of the national professional societies.

At state and local levels the professional societies are much more likely to be less formal and research-oriented; sessions are directed more to colleagual problems in the practice of the profession. Local societies are most apt to choose a presenter whom they know and like and to concentrate on a single subject for an entire day or longer. There is more opportunity for

questions from the participants and the discussions are likely to be related to their practices. In short, at the state and local levels the professional societies are much more likely to be concerned with matters of the delivery of services rather than with clinical diagnosis and therapy only. The topics may feature new legislation, commitment procedures, peer review procedures, insurance coverage for mental disability, etc. This function of keeping the members of a profession up-to-date on new developments which affect how they deliver services is a very significant function of a professional society. It is especially necessary because these matters are usually not taught in basic professional education, and they are in a constant state of change. There is no really satisfactory way for professional persons to keep up with these changes except through the continuing education sessions and newsletters of their society.

Despite some improvements, the continuing education programs of professional societies tend to be designed by a program committee along traditional concepts rather than according to the principles of continuing education. The subject is likely to be the committee's preference rather than a topic determined by a survey of the members' needs and desires. The typical choice of program may be to have speakers who present didactic lectures or scientific papers which have very little relevance for the average practitioner. There is little opportunity for participants to ask questions or to discuss the new concepts, and there is no evaluation or credit for the programs. However, much of this is changing toward a more colleagual continuing education format.

PROFESSIONAL SOCIETY MANDATES FOR CONTINUING EDUCATION

A major reason for the current interest in continuing education is that it is increasingly being required as a condition for relicensure, recertification or renewal of membership. One of the major functions of a professional society is to assure the competence of its members. In recent years this concern has extended to continuing as well as initial competence.

Licensure

Licensure is a legal process of state government which requires that practitioners of a profession demonstrate their qualifications before they are allowed to practice. While the basic purpose is to protect the public from unqualified practitioners, it is most often the professional society itself which administers the law. So far only a few states and professions require continuing education as a condition for relicensure, but this requirement is rapidly expanding to include other states and specialties.

Certification

Certification is a process for awarding a certificate that usually indicates a level of competence beyond that required for basic practice. Often certification is for the practice of subspecialties. The certification process is usually administered by the profession itself or by a closely related body (council, commission or board). Until recently there was little concern for recertification, but this movement has now expanded considerably and is growing. Recertification is often contingent upon participation in a certain number of hours of continuing education.

Membership in a professional society is usually purely elective and carries with it no special sanctions, such as licensure or certification. However, there are many colleagual and professional benefits. An increasing number of professional societies are requiring that to maintain society membership, a member demonstrate that he has participated in a certain amount of continuing education.

All of these processes demonstrate the important role of professional societies in setting the expectations and sanctions for continuing education. This is a very fundamental responsibility of the professional society which cannot be assumed by either academia or by agencies. The professional societies must also assume responsibility for accrediting continuing education programs, awarding of appropriate credits, and keeping records so that the system of sanctions can function smoothly and fairly. These systems are presently emerging, but much remains to be done.

ASSESSING NEEDS AND PLANNING PROGRAMS

The professional societies which have not already done so should clarify the distinction between "scientific sessions" and "continuing education programs." Once the program planning committees understand the importance of making their programs primarily educational rather than stressing the scientific, they will be on the way to new techniques for assessing needs and planning programs.

It is often difficult to assess the needs for continuing education programs for members of a profession who practice in many different settings, agencies and private offices. Surveys and peer review programs are two possible

approaches, but there are still difficulties in assessing which subjects meet truly educational needs and which fill merely personal desires or require administrative solutions rather than continuing education.

The continuing education programs of the professional societies often must be planned in conjunction with the society's business meetings and social events. This requires special arrangements on the part of the continuing education planner but it is likely to increase the attendance.

INSTRUCTION

The professional society, especially at the state or local level, may look to either an academic professor or to a well-known and highly regarded practitioner as the instructor. The format is more likely to be colleagual and participatory, often with small group or case discussions, role playing and other experiential learning exercises. The colleagual atmosphere can be improved by having society members lead small group discussions and presentations of cases following formal presentations by professors. The programs of a professional society tend to be unidisciplinary and to reinforce professional separatism; this may be overcome by having persons from other professions serve as instructors.

FUNDING OR CONTINUING EDUCATION

A difficulty experienced by the professional societies is that of funding. At the national level most major mental health professions have established an office of continuing education with one or more staff persons whose salaries are paid from dues or from grants. Such an office can provide a substantial leadership function, but it obviously cannot plan and conduct education programs

at state and local levels.

Some societies have sought grants or gifts from federal agencies, drug companies, publishing houses and local businesses to support individual continuing education offerings. A few societies have raised dues to cover the costs of their overall continuing education program. This kind of step seems to be the direction for the future. In the meantime most societies charge a fee for each participant for individual offerings and hope that attendance will be sufficient to cover all instructional, planning and evaluation costs.

The practice of charging individual participants a fee to cover the instructional costs of a single offering is common and desirable, but it is not feasible for middle level professions and technologies whose members can not afford high fees.

CONTINUING EDUCATION IN MENTAL HEALTH AGENCIES

The mental health agencies are the third major official group of providers of continuing education programs. Collectively they sponsor half of all the continuing mental health education. Until fairly recent years the agencies, such as mental hospitals, clinics and mental health centers, gave little systematic attention to continuing education. Their major function was and is the delivery of services within the limits of the resources available. Agencies have long had in-service training programs for employees who came on the job with no previous training (i.e. psychiatric aides), and they have orientation programs to acquaint all new employees with the administrative procedures and the programmatic goals and procedures of the agency.

It has become apparent that more must be done to assure the continuing competence of their employees in all aspects of their work -- clinical skills, service delivery skills, and administrative skills. Under the pressures for deinstitutionalization, newly mandated services, and accountability, the agencies have found that they must establish continuing education programs of their own which reach all of their employees. Many agencies have established a staff development officer to give leadership to continuing education along with other aspects of staff training.

The continuing education programs of the mental health agencies are likely to be concerned with matters of the delivery of services and with administrative

issues rather than with matters of clinical skills, which can often be obtained elsewhere. Since the major mission of the agency is the delivery of service, agency-based continuing education programs are usually interdisciplinary and are related to the objectives and procedures of the agency.

Today's demands for cost containment, accountability, program evaluation, etc., make it highly likely that the agencies will also feature administrative content oriented to the patterns and activities of the agency in their continuing education programs. They are apt to be interdisciplinary, but may be limited to top and middle level managers and supervisors.

ASSESSING NEEDS AND PLANNING PROGRAMS

Agencies are in an ideal position to assess needs for continuing education as they observe the practitioner's performance and see his records every day. The agency and its supervisors are in an excellent position to know what kinds of problems and needs their practitioners are experiencing.

Because supervisors and agency heads also know what directions the programs and administrative procedures should take, the content for continuing education programs is rather easily identified. The staff development officer is usually available to help in the design and planning for the program.

AGENCY SANCTIONS FOR CONTINUING EDUCATION

The mental health agency is in a powerful position to stimulate attendance for its own continuing education programs. In many cases it simply directs certain employees to attend certain groups. In other cases supervisors provide a strong expectation that employees will attend. Such sanctions also place the obligation on the agency to keep adequate records of attendance and performance.

Many agencies include records of participation in continuing education in each employee's personnel record and require a certain number of continuing education hours for pay raises or promotions.

INSTRUCTION

The instruction in agency-based continuing education programs is likely to be by a person within the agency, most often a key supervisor or department head. In some cases it may be a person from a university or from a federal or national organization (e.g. The American Management Association) or from elsewhere in state or local government. The style is likely to be fairly directive, but also provides opportunity for discussion and problem-solving simulations. Organizational development approaches are often used. Evaluation is related to improved job performance which can rather easily be observed and measured. This is the highest level of evaluation of continuing education.

FUNDING

Agencies have relatively less difficulty in funding continuing education related to their own mission. Agency funds pay the staff development officer and the salaries or fees for the instructors. This is generally considered a cost of doing business.

A problem arises for agencies when they are asked by employees for time off, registration fees and travel expenses to attend continuing education programs sponsored by academia, professional societies, or the private sector. The agency must establish guidelines for these requests, but there is usually little question about agency-sponsored programs.

There may be some difficulty in obtaining funding for staff development and continuing education in the agency when appropriating bodies are reluctant to spend money on programs other than direct services. This is becoming less of a problem as the standards of accrediting bodies require evidence of a staff development program in order for the agency's programs to be accredited.

ISSUES FOR ALL COMPONENTS IN CONTINUING EDUCATION IN MENTAL HEALTH

The practice of mental health is being changed by a host of current actions and events. Court decisions regarding the right-to-treatment; programs to return to the community persons no longer receiving active treatment; new treatment technologies; demands for services for alcoholics and drug abusers; requirements for services to children and the elderly; mandated programs of consultation and education; new emergency care programs; new kinds of paraprofessional workers; pressures for programs of prevention; demands for accountability; and cost containment are all impacting on the delivery of service.

In looking at the overall picture in continuing education in mental health, it is apparent that there is a need for a clearer assessment of the needs and assignment of resources and responsibilities among the four component groups. While many of the program needs lie in the area of clinical knowledge about diagnosis and treatment, it is clear that many others lie in the areas of service delivery and administration.

There is need for the special expertise and responsibilities of all component groups. We must have a conceptualization of an overall system of continuing education in mental health which defines the legitimate roles for each of the component sponsors and which has concern for service delivery competencies and administrative competencies as well as clinical knowledge and

skills. Once such a system is understood and accepted, the tensions which too often presently exist can more easily be negotiated in the context of the total system.

The previous sections discussed some of the major advantages and disadvantages for each of the official components in the mental health continuing education system. At this time it is appropriate to examine some of the issues which cut across all of the components.

PLANNING AND ARRANGING CONTINUING EDUCATION PROGRAMS

All component groups must give special attention to the planning and arranging of continuing education programs so that they are held at times and places which are most convenient and appropriate for the practitioners. Generally, this will involve scheduling the continuing education offerings close to the practitioners' work setting or during programs they attend regularly. It may also require agencies to make arrangements for time off and meeting places within the agency facility.

If programs must be held at extraordinary times or places, efforts should be made to assure that the facilities are attractive and that other special arrangements have been made (e.g. special transportation, meals, coffee breaks, lodging, social activities, etc.).

Announcements of program offerings must be prepared and distributed early enough for participants to make their arrangements, and provision should be made for pre-registration and confirmation. Last minute reminder cards or telephone calls are often helpful.

DIDACTIC VS. EXPERIENTIAL INSTRUCTIONAL METHODS

Each program must give careful attention to what instructional methods are to be employed. The didactic lecture, panel or film has often been the traditional instructional method. These methods may still be the best when the objective is to impart knowledge alone, but more experiential techniques, such as case discussions, small group discussions, role playing, and videotape playbacks may be more useful if the objective is to improve skills or to enhance clinical and administrative problem solving.

CREDENTIALING CONTINUING EDUCATION

With the increasing requirement for continuing education, it is essential that each component provider group award some appropriate form of credit (Continuing Education Units or Category 1 Continuing Medical Education credits) together with some kind of certificate and record of the credits earned. These credits may then be recognized by licensure boards, certification bodies, employers, etc., for whatever requirements they may have. Hopefully there will be some uniformity of the credits and the system for keeping records. There are many efforts presently under exploration for both standardizing the credit system and centralizing the keeping of records.

In time there will also need to be a uniform method of accrediting continuing education programs so that there can be some assurances of minimum quality. At present only the system for Category 1 Continuing Medical Education has an accreditation program.

EVALUATION OF CONTINUING EDUCATION PROGRAMS

Another issue common to all of the component groups in mental health continuing education is the need for improved evaluation. Too often there has been no systematic evaluation of whether any learning has occurred during the course of any particular continuing education offering or whether there has been any ultimate change in the behavior of the practitioners who participate in the sessions. Such evaluations may be difficult to do, and even expensive at times, but it is important that providers and funding groups know how effective their programs have been and which approaches have been most cost effective.

Perhaps the most readily accessible and most significant evaluation approaches are those which can be carried out through peer review and utilization review procedures which measure changes in practitioners' practice patterns. Agencies and professional societies have relatively easy access to such data. Academia and private sector continuing education programs can arrange with agencies and professional societies to have this kind of evaluation done for their continuing education offerings as well.

SINGLE DISCIPLINARY VS. INTERDISCIPLINARY PROGRAMS

Professional schools and societies tend to feature single discipline programs while agencies need multidisciplinary programs. There are advantages to conducting continuing education programs both ways; however, the world is basically interdisciplinary. Thus, those continuing education offerings that are programmed for a single discipline would do well to avoid promoting the notion that each practitioner is an island unto himself or that any single

discipline is always the center of the treatment or administrative process. Linkages with other disciplines should be suggested and encouraged -- not ignored or belittled.

ACADEMIC RIGOR VS. PRAGMATISM

The universities often feel that academic rigor is being sacrificed to pragmatism in agency practice, while practitioners feel that the university is too theoretical to be practical. Both aspects are important and needed. Academic standards should be maintained whenever possible, but the ultimate test of competence is its practice in the world where many different social values and conditions require that the application of knowledge and skills be appropriately modified.

ASSESSING DEMAND VS. NEED

The prevailing pattern of continuing education has been based on demand by practitioners for certain content areas and formats. This has been necessary in those situations in which the basic financial support for the continuing education program must come from the fees of participants. In a buyer's market there is a tendency to provide what will "sell" rather than what may be more seriously needed by the practitioners. Assessing real needs for continuing education is more difficult for academic institutions and private organizations than for operating agencies where the practitioner's work is more available to evaluate and for professional societies that are in regular touch with their membership through peer review programs and other mechanisms.

VOLUNTARY VS. MANDATORY CONTINUING EDUCATION

Continuing education for the mental health professions is moving from a purely voluntary phenomenon to a requirement. There are vigorous protests from many individuals who argue that merely requiring attendance at continuing education programs will not assure improved competence. They plead for [illegible]datory re-examination of competence rather than continuing education. It is likely that both trends will increase so that there will be both more obligatory continuing education and more re-examination of competence. In some cases re-examination may be offered as an alternative to mandatory continuing education. The demands for accountability for professional practice are simply too great to allow professionals to elect whether or not they wish to keep up-to-date in their knowledge and skills. The overwhelming evidence is that most practitioners keep up if there is a strong mandate that they do so. However, it is also important to assure that mandatory continuing education is related to each practitioner's real practice needs rather than to arbitrary requirements which are inappropriately applied to all practitioners regardless of real need.

FUNDING BY FEES VS. FUNDING BY REGULARLY BUDGETED FUNDS

So far academic institutions, professional societies, and private sector groups have relied heavily on the fees of participants to support their programs, while agencies have generally used regularly budgeted funds. This policy places the programs in a precarious financial state; their financing depends on designing and promoting programs that will sell. While this entrepreneural concept has a certain appeal, it is likely to result in programs

structured around faddish demand and huckster-like promotion rather than around real need. A more realistic pattern would be to have a substantial base of regularly budgeted funds to allow for stability in assessment of needs, planning, evaluation, and record keeping for continuing education. Fees might then be charged to cover instructional costs for individual programs. This is much the same as the basic financial structure of higher education in which there are both regularly budgeted funds from appropriations and endowments for planning and administration and student tuition fees to cover instructional costs.

COORDINATION OF CONTINUING EDUCATION IN MENTAL HEALTH

A major need in the relations of academia, professions and agencies is for coordination of the many mental health continuing education programs. This need will become more of a problem as the mandates for continuing education increase and as more academic institutions, professional societies, mental health agencies, and private sector groups become active in sponsoring continuing education. It is time to give thought to mechanisms for coordinating the future development of continuing education in mental health.

For most areas of the nation it appears that a coordination mechanism for continuing education programs in mental health might best be undertaken at the state level. For a few of the larger states the area may be too large but for most states it seems most practical.

Such a mechanism should be used to coordinate the continuing education efforts of all four major components - academic institutions, professional societies, mental health agencies, and private sector groups. This is a large and complex system. Because the various components do not function under any single administrative head, it is not possible to consider an authoritarian kind of coordinating mechanism. Rather, it will have to be a facilitative kind of coordination that depends on communication and bringing together persons and programs from a) private and public programs, b) all of the mental health professions and occupations, and c) all of the component groups. There

are several possible locations for such a coordinating mechanism:

> The National Institute of Mental Health's Forward Plan for 1978-82 proposes the establishment of a state level mental health manpower development entity in each state. Such a manpower development entity would bring together all of the major manpower actors in the mental health field (mental health agencies, academia, the professional societies, the merit system, etc.) to work on plans for mental health manpower policy planning, utilization, distribution, training, licensure, career development, evaluation, etc. The coordination of continuing education would appear to be a natural responsibility for such a mental health manpower development entity. It will be a few years before such entities become operational in the states, but it is a possible mechanism to keep in mind.
>
> Most states have a coordinating council or commission on higher education which might undertake a broad coordinating role for continuing education in mental health. The coordinating bodies are quite variable in their size and mission. Some are concerned with only the state-operated colleges and universities; others relate to private institutions as well. Most have not yet addressed issues of continuing education, but continuing education in mental health might provide a good beginning.
>
> The state mental health agency or the state human resources agency in most states has a staff development office which might assume the responsibility for coordinating all continuing education in mental health. These staff development offices vary in size and function. In a few states it might be more appropriate to consider using the planning office within the state mental health agency if there is no staff development program.
>
> Still another possibility might be in the manpower section of the new State Health Planning and Development Agencies. These structures are still too new to know how likely this suggestion may be.

Whatever the location and formal structure of the coordinating body for continuing education in mental health, there should be provision for participation by a) the state's professional and occupational training schools, b) the state's professional societies, c) the major state, local, private, and federal

mental health agencies (e.g. major veterans administration neuropsychiatric hospitals) and d) major private or voluntary continuing education programs in the state. It might be desirable to have certain other manpower interests represented as well (e.g. the licensure boards, the state personnel department, a legislator, or a representative from the budget division).

At first a state level coordinating body might concentrate on simply bringing together the state's major components in continuing education in mental health so that they get to know each other and learn about each other's individual activities and plans in continuing education. Such meetings would facilitate the development of a state level perspective on what is underway and the problems and unmet needs in continuing education.

Among the specific items which might be facilitated by a coordinating body are:

Sharing of needs assessments
There is no point in having each of the component groups carry its own needs assessment if these could be shared.

Joint planning and scheduling of programs
Because of the present method of independent planning an agency and a professional school could be planning parallel programs. A coordinating body might function to learn about planning activities of this kind and put the planners in touch with each other so that a single joint program could be arranged.

Sharing of instructional resources (faculty, equipment, Classrooms, etc.)
This might be especially fruitful in bringing about interdisciplinary programs using outstanding instructors from many disciplines or specialty areas (i.e. administration, program evaluation, prevention). The community colleges often provide instructional resources which are not considered in planning by professional societies and agencies.

A coordinating committee might help put together top faculty from several professions, universities and agencies to be used for any component group's programs. The committee might also help identify resource faculty for specialized subject areas, such as administration, geropsychiatry, prevention, law, or sociology.

The committee might also offer technical assistance or training workshops for persons who frequently serve as faculty for continuing education programs in such subjects as curriculum development or the use of experiential learning techniques (simulation, games, videotape playbacks, etc.).

Sharing of promotional efforts

Program announcements could be distributed more widely to key persons to improve participation. A periodic compilation of all programs might be circulated to all component groups.

The committee should also attempt to coordinate the continuing education programs being developed and promoted by the private sector as well as official groups. Some of these programs are excellent and should be an integral part of the state's overall continuing education offerings.

Sharing of evaluation methodologies and certification and record keeping

These procedures are presently weak or non-existent in many continuing education programs. A coordinating group might expedite their development for all component groups.

Sharing and strengthening of efforts to obtain more stable funding

A coordinating body could articulate the funding needs for all of the component groups and relay these to responsible decision makers in governing bodies, budget offices and legislatures.

Eventually such a coordinating body might set forth a formal continuing education plan for the state which would include:

Goals and Purposes

Inventory of Programs and Structures

Inventory of Needs

Inventory of Potential Resources
-financial
-manpower
-constraints

An overall Plan for Coordinating
the Component Parts

Strategies for Implementation

The idea of a planning-coordinating body could be carried down to the local level with local committees of counterpart persons to those at the state level. Such local bodies might be especially helpful in large urban areas which have a wealth of continuing education resources that are poorly coordinated presently.

A state level coordinating body for continuing education in mental health could not be expected to function without paid assistance. There should be some funding and staff for this coordinating body. This funding might come from state or federal sources through regular appropriations, grants or contracts. If state mental health manpower development entities come into being as proposed by NIMH, this source of funding might be used for the coordination of continuing education as well.

EXAMPLES OF COORDINATION AND COLLABORATION

While there are no existing state models that offer a comprehensive range of coordination for continuing education in mental health such as that proposed here, there are some examples of state level coordination of various other aspects of educational and manpower planning for mental health. One of these is North Carolina's Multiversity which brings together the departments of

psychiatry, social work, nursing and public health from several universities along with the state mental health agency. This group meets monthly to do overall educational planning in mental health. The Kentucky Mental Health Manpower Commission (now Kentucky Manpower Development, Inc.) is an organization made up of professional and agency persons plus representatives from the state personnel department and from the Council on Public Higher Education (which has existed since 1961) to plan and coordinate mental health training and manpower development in that state.

At present there are no national organizations concerned primarily with coordination of continuing education in mental health. Several of the national professional organizations have continuing education committees and staff to formulate policies and programs, but these do not regularly coordinate their activities with each other or with the Continuing Education Branch or the Staff College of the National Institute of Mental Health. There are regional groups beginning to develop in the West (through a project at the Western Interstate Commission on Higher Education) and in the South (through the Southern Regional Education Board). These regional groups can facilitate continuing education in mental health in their regions, especially for those programs which are best planned and shared across state lines. They can also help speed developments within states by exchanging progress reports and solutions to problems across state lines. However, it still seems desirable to have a national level group to coordinate much of the coming program development in mental health continuing education and to articulate more clearly the case for continuing education in mental health. This would facilitate overall development of continuing education and lead to greater uniformity of quality and procedures.

SUMMARY

The expanding and changing roles in mental health and mental retardation call for continuing education in the competencies required to deliver varied and complex services. Each of the principals -- academia, professions and agencies -- has a unique and special contribution to make to this field. If specific roles are clarified and mechanisms for collaboration are developed, effectiveness of all can be maximized. While some functions overlap, major roles fall within the following responsibilities.

Professional Associations	Professional Schools	Mental Health Agencies
Stimulating	Instructing	Assessing Needs
Sanctioning	Administering	Sanctioning
Accrediting	Evaluating	Evaluating
Licensing		Administering

All have some relation to
- Arranging
- Funding
- Programming
- Certifying
- Keeping Records

In considering the relations of academia, professions and agencies, certain basic principles can be followed in inaugurating and following through on collaboration. These are:

There should be coordination and linkage between and among graduate education, in-service training, and pre-service education.

There should be a continuum of education for Mental Health-Mental Retardation Services up to and through continuing education.

There should be evaluation of all programs.

There should be a coordinating plan for continuing education which is integrated for state and local personnel.

There should be an individual at the state level with designated responsibility for the coordination and integration of continuing education in mental health.

The state plan for continuing education should be a part of the overall plan for Mental Health-Mental Retardation Services and should be in concert with goals and plans of the educational and professional society systems.

There should be a budget at state and local levels for mental health continuing education.

Significant beginnings have been made toward the effective collaborations of academia, professions and agencies in developing mental health continuing education programs. Leaders from these three components of the overall system have recognized that there is inadequate communication, sharing and mutual program designing to meet common purposes. There are difficulties some of which are attitudinal and others which are based in reality.

Goals and purposes of agencies and institutions are varied and the level of expertise is different in different places. Within all this variation, however, it has been demonstrated in some places that the efforts of academia, professions and agencies can be brought into harmony and orchestration.

Guidelines for the administrative and procedural aspects of mental health-mental retardation continuing education have been presented, particularly as they relate to the respective and collective roles of the professional schools, professions and their societies and the agencies which have responsibilities for the delivery of services. A more systematic and coordinated approach by all of the component groups will result in stronger, more efficient and more effective programs of continuing education in mental health.

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